



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2093-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fees should be paid in accordance with DWC Rule 134.404. Hospital Facility Fee Guideline – Inpatient...According to Medicare Inpatient Pricer 2011.2 PSF 04/11 (Dischrgs 10/2010-09/2011), the correct reimbursement rate for this procedure is \$13,377.59. After adding the 143% multiplier as established by DWC Rule 134.404, the total reimbursement rate is \$19,129.95...We submitted request for reconsideration with supporting documentation but no additional reimbursement was recommended."

Amount in Dispute: \$5,726.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted a request for medial dispute resolution on February 16, 2012 for healthcare services provided from April 28 through April 30, 2011 and is seeking reimbursement in the amount of \$5,726.29. The carrier relies upon its review and reduction of the provider's bill as reflected in its EOB's. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive, Ogden & Latson, P. O. Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2011 To April 30, 2011	Inpatient Hospital Surgical Services	\$5,726.29	\$5,726.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for

inpatient services.

3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
 - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 19, 2011

 - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

Explanation of benefits dated October 5, 2011

 - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
 - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 490 is \$13,377.59. This amount multiplied by 143% is \$19,129.95. The total maximum allowable reimbursement (MAR) is therefore \$19,129.95. The respondent previously paid \$13,403.66, therefore an additional amount of \$5,726.29 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$5,726.29.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$5,726.29 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ May 23, 2012 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.